FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021766

Facility Name: Meadows

Address: 3250 South Plum Grove Road (Number) Rolling Meadows (City) 60008 (Zip Code)

County: Cook

Telephone Number: (847) 397-0055 Fax # (847) 397-0477

IDPA ID Number:

Date of Initial License for Current Owners: 08/1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jean Adaskivich Telephone Number: (847) 397-0055

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Jean Adaskivich
(Title) Administrator

Paid Preparer

(Signed) March 11, 2004 (Date)
(Print Name and Title) Mr. Robert Rein, Practitioner
(Firm Name & Address) Robert Rein CPA, P.O. Box 201, Morton, Illinois 61550-0201
(Telephone) (309) 266-8178 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	99	Intermediate/DD	99	36,135	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	35,121	730		35,851	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,121	730		35,851	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.21%

D. How many bed-hold days during this year were paid by Public Aid?
798 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 08/1975 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/200 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	215,530	10,683	4,232	230,445		230,445	(5,911)	224,534			1
2	Food Purchase		113,356		113,356		113,356		113,356			2
3	Housekeeping	94,937	23,225		118,162		118,162		118,162			3
4	Laundry	111,173	16,698		127,871		127,871		127,871			4
5	Heat and Other Utilities			78,850	78,850		78,850		78,850			5
6	Maintenance	75,746	7,533	29,509	112,788		112,788		112,788			6
7	Other (specify):*											7
8	TOTAL General Services	497,386	171,495	112,591	781,472		781,472	(5,911)	775,561			8
	B. Health Care and Programs											
9	Medical Director			28,800	28,800	(20,160)	8,640		8,640			9
10	Nursing and Medical Records	1,052,938	26,586	50,973	1,130,497	(7,261)	1,123,236		1,123,236			10
10a	Therapy	30,980			30,980	7,763	38,743		38,743			10a
11	Activities	92,721	5,843	210	98,774		98,774		98,774			11
12	Social Services	175,801		17,056	192,857	(7,763)	185,094		185,094			12
13	Nurse Aide Training					7,861	7,861		7,861			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,352,440	32,429	97,039	1,481,908	(19,560)	1,462,348		1,462,348			16
	C. General Administration											
17	Administrative	127,622		30,000	157,622		157,622	(51,280)	106,342			17
18	Directors Fees											18
19	Professional Services			72,003	72,003	(1,017)	70,986		70,986			19
20	Dues, Fees, Subscriptions & Promotions			10,822	10,822	3,074	13,896		13,896			20
21	Clerical & General Office Expenses	109,587	7,018	(15,467)	101,138	(2,904)	98,234	27,462	125,696			21
22	Employee Benefits & Payroll Taxes			398,363	398,363	2,117	400,480	(11,745)	388,735			22
23	Inservice Training & Education			2,250	2,250	(2,250)						23
24	Travel and Seminar			955	955	380	1,335		1,335			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,833	40,833		40,833	8,983	49,816			26
27	Other (specify):*											27
28	TOTAL General Administration	237,209	7,018	539,759	783,986	(600)	783,386	(26,580)	756,806			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,087,035	210,942	749,389	3,047,366	(20,160)	3,027,206	(32,491)	2,994,715			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Meadows #0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			2,098	2,098		2,098	77,591	79,689			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							225,879	225,879			32
33	Real Estate Taxes							205,071	205,071			33
34	Rent-Facility & Grounds			729,600	729,600		729,600	(729,600)				34
35	Rent-Equipment & Vehicles			10,994	10,994		10,994		10,994			35
36	Other (specify):*											36
37	TOTAL Ownership			742,692	742,692		742,692	(221,059)	521,633			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			7,793	7,793	20,160	27,953		27,953			39
40	Barber and Beauty Shops			6,566	6,566		6,566		6,566			40
41	Coffee and Gift Shops			(2,221)	(2,221)		(2,221)		(2,221)			41
42	Provider Participation Fee			222,311	222,311		222,311		222,311			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			234,449	234,449	20,160	254,609		254,609			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,087,035	210,942	1,726,530	4,024,507		4,024,507	(253,550)	3,770,957			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,580	30.3		9
10	Interest and Other Investment Income	(6,008)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		21.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(62,724)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (63,152)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(190,398)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (190,398)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (253,550)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule MD	x		20,160	9.3	46
47	TOTAL (C): (sum of lines 38-46)			$ 20,160		47

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Byrn T. Witt	50%	Zachary House	Streamwood			
Barbara S. Witt	50%	Zachary House	Streamwood			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 729,600	Byrn T. Witt & Barbara S. Witt	100.00%	$	$ (729,600)	1
2	V	17	Management Fee	30,000	Byrn T. Witt & Barbara S. Witt	100.00%	18,000	(12,000)	2
3	V	30	Depreciation		Byrn T. Witt & Barbara S. Witt	100.00%	95,420	95,420	3
4	V	32	Interest		Byrn T. Witt & Barbara S. Witt	100.00%	231,887	231,887	4
5	V	17	Life Insurance		Byrn T. Witt	50.00%			5
6	V	33	Real Estate Taxes		Byrn T. Witt & Barbara S. Witt	100.00%	205,071	205,071	6
7	V	17	Financial	43,096	Robin Witt		43,096	0	7
8	V	26	Property Insurance		Byrn T. Witt & Barbara S. Witt	100.00%	18,824	18,824	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 802,696			$ 612,298	$ * (190,398)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Byrn T. Witt		Administrator	50%		7.2	60%	Salary	$ 18,000	17.3	1
2	Robin Witt	Chief Financial Officer	Administration			24	60%	Salary	43,096	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 61,096		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3	HUD		X	Debt Refinance / Bldg Construction	Varies	8/31/1995	2,702,300	2,627,633	3/31/1936	8.80%	231,887	3
4										Interest Income Adju	(6,008)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,702,300	$ 2,627,633			$ 225,879	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,702,300	$ 2,627,633			$ 225,879	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	197,391	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	201,231	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,840	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	201,231	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	205,071	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	203,155	8
1999	205,780	9
2000	208,444	10
2001	197,391	11
2002	201,231	12

Based on estimate from county treasurer.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meadows COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0021766

CONTACT PERSON REGARDING THIS REPORT Jean Adaskivich

TELEPHONE (847) 397-0055 FAX #: (847) 397-0477

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-35-100-016-0000	3250 South Plum Grove Road	$ 201,231.00	$ 201,231.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 201,231.00	$ 201,231.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,000 B. General Construction Type: Exterior Brick Frame Concrete Block Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	52,300	6/1/1986	$ 25,000	1
2					2
3	TOTALS	52,300		$ 25,000	3

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1986	1975	$ 1,500,000	$	30	$ 50,000	$ 50,000	$ 1,367,366	4
5			1996	1996	1,478,674		39	37,915	37,915	284,518	5
6			1996	1996	15,000		39	385	385	2,777	6
7											7
8											8
	Improvement Type**										
9	Remodeling			01/01/76	3,548		10			3,548	9
10				01/01/77	21,344		10			21,344	10
11				01/01/79	169		10			169	11
12				01/01/80	9,111		10			9,111	12
13				01/01/81	3,203		10			3,203	13
14				01/01/83	7,355		10			7,355	14
15				01/01/84	11,356		10			11,356	15
16	Garage			01/01/85	3,165		10			3,165	16
17	Remodeling			01/01/86	2,386		10			2,386	17
18	Water Heater & Fire Alarm System			01/01/87	3,199		15			3,199	18
19	Roof			01/01/88	40,520		20			40,520	19
20	Heat Pump			01/01/88	1,900		15			1,900	20
21	Carpeting			01/01/88	10,119		5			10,119	21
22	Carpeting			01/01/89	4,185		5			4,185	22
23	Roof			01/01/90	3,527		20	176	176	3,076	23
24	Kitchen			01/01/90	2,319		10			2,319	24
25	Heater Repairs			01/01/91	840		7			840	25
26	Improvements			01/01/93	737		10	68	68	737	26
27	Water Heater			03/31/95	3,000		7			3,000	27
28	Air Conditioners			08/01/95	5,627		5			5,627	28
29	Unit Heaters			12/05/95	737	19	5		(19)	737	29
30	Exterior Doors			05/23/95	628	16	39	16		138	30
31	Garage Door			06/30/96	385		10	39	39	292	31
32	Parking Lot Repair			06/30/96	6,655		20	333	333	2,499	32
33	Driveway			06/30/96	22,572		20	1,129	1,129	8,472	33
34	Walk-in Freezer & Cooler			06/30/96	12,333		10	1,233	1,233	9,253	34
35	Air Conditioning Units			09/04/96	3,554		5			3,554	35
36	Draperies			06/30/97	16,239		39	416		2,706	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fencing	06/30/97	$ 8,090	$ 207	39	$ 207	$	$ 1,347	37
38	Windows & Doors	06/30/97	2,128		39	55	55	358	38
39	New Building Addition	01/01/98	7,500		39	192	192	1,152	39
40	Time Clock System	06/30/99	8,785		5	1,757	1,757	7,914	40
41	Air Conditioning Units	06/30/99	7,589		5	1,518	1,518	6,837	41
42	Time Clock System	07/31/01	1,452		5	290	290	702	42
43	Telephone Equipment	02/08/01	1,850		5	370	370	1,070	43
44	Air Conditioning Units	06/13/01	4,568		39	117	117	299	44
45	Window Screens	06/20/01	1,400		39	36	36	91	45
46	Draperies	02/15/01	4,118		39	106	106	304	46
47	Magnetic Door Holders	01/25/02	1,350		7	180	180	360	47
48	6 Air Conditioner Units	08/21/02	4,671		39	43	43	86	48
49	12 Resident Room Closet Doors	08/02/02	2,346		39	25	25	50	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,250,234	$ 242		$ 96,606	$ 95,948	$ 1,840,041	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 103,588	$	$ 4,636	$ 4,636	Various	$ 84,527	71
72	Current Year Purchases					Various		72
73	Fully Depreciated Assets	111,071					111,071	73
74								74
75	TOTALS	$ 214,659	$	$ 4,636	$ 4,636		$ 195,598	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	'94 Dodge Van	04/01/96	$ 8,776	$	$	$	5	$ 8,776	76
77	Patient Transport	'94 Ford Champion Van	09/20/96	26,000				5	26,000	77
78										78
79										79
80	TOTALS			$ 34,776	$	$	$		$ 34,776	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,524,669	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 242	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 101,242	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 100,584	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,070,415	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Meadows STATE OF ILLINOIS # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 10,994 Description: Copier: $7,345; Mailing Machine: $3,649
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		60		60
3	Classroom Wages (a)		3,844		3,844
4	Clinical Wages (b)		1,922		1,922
5	In-House Trainer Wages (c)		1,435		1,435
6	Transportation				
7	Contractual Payments		600		600
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 7,861	$	$ 7,861
10	SUM OF line 9, col. 1 and 2 (e)	$ 7,861			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		79	3,160		79	3,160	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits		202	20,160		202	20,160	5
6	Dental Care	39.3	visits		78	7,793		78	7,793	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Exceptional Care	39.2								13
14	TOTAL			$	359	$ 31,113	$	359	$ 31,113	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 735,886	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	995,919		3
4	Supply Inventory (priced at FIFO)	4,080		4
5	Short-Term Investments	633,454		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	17,076		7
8	Accounts Receivable (owners or related parties)	(532,449)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 1,853,966	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,455		15
16	Equipment, at Historical Cost	258,134		16
17	Accumulated Depreciation (book methods)	(203,819)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 63,770	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 1,917,736	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	(773)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ (773)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ (773)	$	46
47	TOTAL EQUITY(page 18, line 24)	$ (1,916,963)	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ (1,917,736)	$	48

*(See instructions.)

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 1,531,533	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 1,531,533	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	524,298	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(138,868)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	$ 385,430	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	$ 1,916,963	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (4,502,694)	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ (4,502,694)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(24,557)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ (24,557)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ (4,527,251)	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	781,472	31
32	Health Care	1,481,908	32
33	General Administration	783,986	33
	B. Capital Expense		
34	Ownership	742,692	34
	C. Ancillary Expense		
35	Special Cost Centers	12,138	35
36	Provider Participation Fee	222,311	36
	D. Other Expenses (specify):		
37			37
38	Gain on Sale of Fixed Assets	(21,554)	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 4,002,953	40
41	Income before Income Taxes (line 30 minus line 40)**	(524,298)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (524,298)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,038	2,248	$ 72,437	$ 32.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,476	8,458	158,583	18.75	3
4	Licensed Practical Nurses	3,879	4,349	103,403	23.78	4
5	Nurse Aides & Orderlies	20,701	22,703	278,476	12.27	5
6	Nurse Aide Trainees	600	600	5,766	9.61	6
7	Licensed Therapist	1,117	1,143	10,177	8.90	7
8	Rehab/Therapy Aides	1,158	1,284	20,803	16.20	8
9	Activity Director					9
10	Activity Assistants	6,367	7,331	92,721	12.65	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,602	1,790	25,435	14.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,186	15,539	184,184	11.85	15
16	Dishwashers					16
17	Maintenance Workers	3,899	4,502	75,746	16.83	17
18	Housekeepers	8,672	9,593	94,937	9.90	18
19	Laundry	9,935	10,676	111,173	10.41	19
20	Administrator	1,474	1,561	45,246	28.99	20
21	Assistant Administrator					21
22	Other Administrative	800	1,248	43,096	34.53	22
23	Office Manager					23
24	Clerical	4,544	5,164	93,570	18.12	24
25	Vocational Instruction	80	80	1,435	17.94	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,345	12,421	175,801	14.15	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	34,544	36,978	376,301	10.18	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Behavior Dev'l	3,926	4,168	56,539	13.56	33
34	TOTAL (lines 1 - 33)	138,343	151,836	$ 2,025,827 *	$ 13.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	100	$ 4,160	1.3	35
36	Medical Director	86	8,640	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	129	6,440	10.3	38
39	Pharmacist Consultant	13	1,950	10.3	39
40	Physical Therapy Consultant	68	3,890	10a.3	40
41	Occupational Therapy Consultant	13	713	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	6	180	12.3	45
46	Other(specify) Psychlogist	23	2,300	12.3	46
47	Behavioir Dev'l Consultant	6	308	12.3	47
48	Psychiatrist	61	6,100	12.3	48
49	TOTAL (lines 35 - 48)	505	$ 34,681		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	722	41,346	10.3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	722	$ 41,346		53

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jean Adaskivich	Administrator	-0-	$ 55,795
Robin Witt	CFO	-0-	71,827
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 127,622

B. Administrative - Other

Description	Amount
Byrn Witt	$ 30,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 30,000

C. Professional Services

Vendor/Payee	Type	Amount
Clifton Gunderson	Accounting	$ 9,075
Bell, Boyd, & Lloyd	Legal	48,406
Robert Rein, CPA	Consulting	4,883
Christenson Computer	Computer	3,891
Information Control	Consulting	1,112
Achieve Health	Computer	3,181
Reclassification		1,455
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 72,003

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,874
Unemployment Compensation Insurance	10,749
FICA Taxes	154,782
Employee Health Insurance	169,835
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Appreciation	5,941
Employee Life/Disability	15,182
Employee Physicals	2,117
Allocation of Benefits	(11,745)
TOTAL (agree to Schedule V, line 22, col.8)	$ 388,735

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 505
Advertising: Employee Recruitment	4,188
Health Care Worker Background Check	397
(Indicate # of checks performed 30)	
IARF Membership Dues	5,744
Other Dues & Licenses	56
Sec of State/City of Rolling Meadows	644
Subscriptions	112
Illinois Council on Training	2,250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,896

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	320
Seminar Expense	1,015
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,335

**See instructions.

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2003 Ending: 12/31/200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IARF Membership Dues 5,744

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 3,691 Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 222,311
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees